
Debate

Metaphysics and medical ethics

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Abstract

I take issue with Frank Leavitt's sketch of a pragmatic criterion for the relevance of metaphysics to medical ethics. I argue that appeal to the potential for confusion generated by metaphysical subtlety establishes a need for better communication rather than shows philosophical insight beside the point. I demonstrate that the proposed Criterion of Relevance has absurd consequences, and I claim that the relevance of philosophical doctrines, whether ethical or metaphysical, is best accounted for in terms of improved understanding.

I propose to take issue with some of the claims made by Frank J Leavitt in his recent paper 'Let's keep metaphysics out of medical ethics: a critique of Poplawski and Gillett' (1). Let me say at once that I am generally in sympathy with the substantive thesis of his paper, namely, that the metaphysical concept of longitudinal form contributes little if anything to the clarification of the ethics of abortion. However, the reasons why the concept of longitudinal form is set aside repay further investigation, for it turns out that the author is not just defending the limited view that a particular metaphysical concept – longitudinal form – fails to enlighten when introduced into a particular ethical debate – concerning abortion – but subscribes to a general view about the relation of metaphysics and medical ethics. With this strand of his paper I am almost entirely out of sympathy.

Leavitt's own nutshell summary of his position in his authorial abstract is that the concept of longitudinal form 'involves too many metaphysical subtleties' (page 206), so his complaint is that the concept is in a sense too rich to do the job its protagonists had claimed it could do. But that is not quite right either. The concept of longitudinal form is apt, Leavitt elaborates, to convey a certain metaphysical view, whether or not we subscribe to it, but in conveying that view 'it raises so many subtle

philosophical questions' (page 206) that the author doubts 'whether it can be of value for medical ethics' (page 206).

If we ask further what makes a view or concept of value to medical ethics, Leavitt's answer is clearly a pragmatic one; it must 'be a useful aid to making moral decisions' (page 206). He thus appears to espouse a conception of medical ethics which is rather narrower than I would be happy with but I do not propose to challenge that conception until the closing paragraphs of this paper.

To continue. The reason why the concept of longitudinal form is to be ejected from the abortion debate is that it is pragmatically inappropriate; it does not aid medical ethics in its task of helping people to make moral decisions about abortion. Moreover, the pragmatic shortcomings of the concept are directly related to its philosophical sophistication. A certain kind, or perhaps level, of subtlety is likely in practice only to 'confuse the people whom medical ethics ought to be helping' (page 206).

The situation, then, is that certain concepts may be sufficiently sophisticated as to be *both* useful tools for metaphysical purposes *and* a source of confusion for certain practical purposes. Indeed, the very sophistication which may make a concept or view philosophically attractive is likely to be precisely what makes that same concept or view confusing in practice.

This point of view makes a number of assumptions. One is that those who make practical decisions in medical ethics are philosophically untutored, a reasonable enough assumption though there are substantial and, one trusts, increasing exceptions. Another is that confusion is not of value for medical ethics, again a reasonable enough generalization though perhaps too quickly asserted. There are individuals who respond to confusion about what they ought to do by thinking of it as a challenge to be met by engaging in more careful and more conscientious decision-making than they otherwise would. In their case at least, confusion, if not itself exactly a useful aid in making moral decisions, is nonetheless of value to medical ethics as a kind of catalyst for improved decision-making.

Key words

Applied ethics; medical ethics (nature of); metaphysics; moral decision-making; moral philosophy; philosophical ethics; philosophical inquiry; practical relevance; rival philosophical doctrines.

But, having noted these reservations, let me agree that confusion rarely enhances the quality of practical decisions, and that most people do find many philosophically sophisticated concepts and views confusing.

Better communication needed

Even on the assumptions just made it does not follow that we ought to keep metaphysics out of medical ethics. Philosophers who rally to the banner of Leavitt's title may, somewhat ironically, find themselves in a position not unlike that of the paternalistic physician of yesteryear. I have in mind those who were wont to argue that the very scientific sophistication of much modern medical knowledge meant that its full disclosure to patients and other decision-makers was more likely to confuse than to enlighten. The response, of course, was to admit that scientific peers may converse with a depth of shared knowledge and in a language of technical rigour which of their nature exclude from participation those who lack the training and experience to qualify as members of the peer group, but to deny that such an admission justified the paternalistic conclusion. What counts as full disclosure for the purposes of informed consent does not have to match the expert niceties of a consultants' forum. The obvious need, it was concluded, was for better communication. No doubt what counts as good communication, and hence as improvement in communication, depends on many factors. Central among them, however, is a style and language of expression which both makes sense to the lay person and is at least consistent with subtlety of scientific insight.

If the deliverances of philosophers do indeed confuse rather than clarify practical moral issues in medical ethics *on account of their subtlety*, and I do not for a moment doubt that this in fact occurs, though it may be impossible to assess on just how large or small a scale, then I believe that the diagnosis and antidote are alike clear enough. Professional philosophers do their job with extremely sophisticated conceptual tools and in a rigorous language to match. It is not surprising that much of what they achieve may make little sense to, or may even actively confuse, those who lack the training to be practitioners.

The lay person *vis-a-vis* philosophy will probably take this point readily enough in the context of metaphysics or philosophical logic but may not so readily appreciate that it applies equally to moral philosophy or (philosophical) ethics. One reason why moral philosophy seems to be, and in a sense is, more accessible to the lay thinker is that the development of medical ethics and other branches of applied ethics has required moral philosophers to communicate the insights of their special discipline in a manner and vocabulary suited to practical decision-making rather than in those in which the

insights were originally sought and formulated. And if those who might have looked to moral philosophy for practical help end up being confused by the fare they are offered, that need not show that moral philosophy is practically useless. It is as likely to be evidence that philosophers are still learning how to communicate better.

A similar point can be made about metaphysics. Let us concede that the concept of longitudinal form is a philosophically subtle concept, and that its introduction into an analysis of the ethics of abortion *as a philosophically subtle concept* is more likely to confuse than to clarify. That need not show that the metaphysical insights acquired and expressed in that language have nothing to offer the abortion debate; it may show that the insights in question must be better communicated if they are to help and not hinder. A style and language of expression suitable for the philosophical conference room may be wholly out of place on a ward-round or in a multidisciplinary team meeting. But what is communicated should be at least consistent with subtlety of philosophical insight.

Leavitt's response might well be, and what follows is, of course, conjecture based on my understanding of his paper, to query the analogy on which the position just developed relies. We can have confidence that the sophisticated knowledge of the specialist physician is of relevance to the practical needs of the patient, hence the imperative to translate it into a form in which it is of practical use. If the analogy is sound, we can have comparable confidence that the sophisticated knowledge of the specialist metaphysician is relevant to the needs of medical decision-makers, hence an imperative to translate it too into a form in which it might be of practical use. But Leavitt's doubts about the value to medical ethics of metaphysical views and concepts turn out to be doubts about their relevance; and if he is correct, then it follows that the analogy cannot after all be relied on.

Leavitt's position, then, is not that metaphysical views are too easily intruded into medical ethics in ways which confuse rather than clarify, for an obvious solution to that problem is to communicate them in ways which do not confuse. His position is apparently the stronger one that metaphysics does not belong in medical ethics at all and should therefore be kept out. I say 'apparently' as he is not entirely consistent in what he asserts, as I shall shortly demonstrate.

The general idea seems to be that certain concepts, such as longitudinal form, while perfectly acceptable for some philosophical purposes, are not acceptable for practical, especially moral, purposes. The former, let us call them metaphysical concepts, belong in discourse which is pure, theoretical, and which makes no difference; whereas moral concepts figure in discourse which is applied, practical, and which does make a difference.

This is borne out by some remarks near the close of the essay. In comparing two views, and the remark is a general one which is thus not restricted to the two particular views which in fact prompted it, Leavitt says that a distinction between them may be described as 'metaphysical' where 'the distinction is morally irrelevant: neither view requires us to act any differently from what the other view requires' (page 208). I note again that moral relevance is rather narrowly conceived, namely as what makes a practical difference to what we do or decide to do.

Later on Leavitt emphasizes that dubbing a view 'metaphysical' is intended 'to stress that it ... has no import with respect to practical, moral decision-making ...' (page 208). In short, a view's being metaphysical thereby disqualifies it from being morally relevant. The task of the Criterion of Relevance, to which I shall return, is that of 'distinguishing what is merely metaphysical from what is morally relevant' (page 208). The stronger version of Leavitt's position thus makes the metaphysical and the morally relevant mutually exclusive. Metaphysics is a source of confusion in medical ethics not on account of a curable oversophistication but rather because its views and concepts do not belong there at all. This is not to denigrate metaphysics. On the contrary, metaphysics may be entirely worthwhile 'as an independent field of enquiry' (page 208) to which many philosophers devote much of their professional time.

However, when Leavitt allows that 'the discipline of metaphysics may have some useful concepts to contribute to medical ethics' (page 208), he does so on pain of inconsistency. Concepts which are useful to medical ethics are concepts which aid practical decision-making, which are morally relevant in the sense that they make a difference to how we act or decide to act. Metaphysical concepts are morally irrelevant in precisely that sense, so how could they conceivably make a contribution to medical ethics?

We have seen that Leavitt's intention in dubbing a view metaphysical was 'to stress that it ... has no import with respect to practical, moral decision-making ...' (page 208). It was also his intention to signify that the view or concept thus described 'introduces unnecessary subtleties into medical ethics' (page 208). This renewed reference to, presumably philosophical, subtleties may be no more than a verbal variant of what the author has just stressed: that the metaphysical lacks practical import. The subtleties are unnecessary because morally irrelevant in the sense described, or because a source of confusion as discussed above.

They may, however, be unnecessary in another sense which is suggested by Leavitt's remark that 'the longitudinal view engenders more philosophical puzzles than it clarifies moral issues' (page 208). Here the subtlety of the longitudinal view appears to be evidence of, or at the very least associated with, its

controversial status. The argument might then run: abortion is a highly controversial moral issue; using a controversial metaphysical doctrine to clarify a controversial moral issue is more likely to compound than to dispel controversy; controversy compounded is confusing; so let us keep metaphysics out of medical ethics.

The trouble with an argument of this sort is that it depends at a crucial point on a comparative likelihood, and comparative likelihoods are notoriously treacherous to assess with any reliability. But, fortunately for present purposes, we can agree to the likelihood claimed above consistently with conceding, as Leavitt does himself, that metaphysics may sometimes have something useful to contribute. Even in the controversial cases it is not clear that the metaphysical considerations have been shown to be irrelevant; they may simply be inconclusive.

Criterion of Relevance

I turn now to Leavitt's Criterion of Relevance. This is introduced to provide, as a rough sketch for further discussion, 'a criterion for distinguishing what is merely metaphysical from what is morally relevant' (page 208). Inspired, interestingly, both by a form of verificationism and by a tradition of rabbinic disputation, Leavitt's Criterion of Relevance is stated thus: 'a philosophical doctrine is relevant for medical ethics if and only if someone who holds it ought to act differently in particular practical moral situations, from someone who holds a competing doctrine' (page 208). This rough sketch is tendered to help make progress with the important and vexed question of when the sorts of things philosophers do for much of their professional time might be of some use to, ie, have some practical relevance for, the sorts of decisions health professionals and their patients or clients have to make. But even making generous allowance for the admitted roughness of the sketch, I think the proposed criterion will not do. For instance, one curious feature of the criterion is that it makes the relevance of a philosophical doctrine turn on a comparison between it and one or more rivals. But it is not clear why a philosophical doctrine is relevant only when it has a rival, nor, alternatively, why any philosophical doctrine should always have a rival. And if all that is intended is that for any given doctrine we always have the option of holding or rejecting it, that seems a fairly tame sort of rivalry. However, I shall not pursue this feature of the proposal, as I think there are larger issues to be explored.

If we take the proposed criterion at its face value, it has the surprising consequence of ruling out the relevance for medical ethics of many, perhaps all, ethical theories. Consider briefly the two philosophical doctrines which are standard competitors in (philosophical) ethics: Consequentialism and

Kantianism. If Joe Consequentialist decides that it would be wrong for him to attack, rob and sexually violate Elderly Neighbour, this gives us no reason to expect that Jo Kantian, who holds a competing philosophical doctrine, will decide that she ought to do so or even that she might be permitted to do so. In fact there are dozens, or rather literally innumerable, particular practical moral situations in which Joe and Jo will not disagree at all as to how they ought to behave. Sometimes they will disagree. I do not know how to compute how often that is likely to be. My guess is that the agreements will far outnumber the disagreements. But if Consequentialism and Kantianism are competing philosophical doctrines without its following that those who hold the respective doctrines ought to act differently in moral practice, then they fail to meet Leavitt's Criterion of Relevance to medical ethics.

How can we explain this surprising result? Saying that someone ought to act differently in particular practical moral situations turns out not to be a precise enough formulation for the purpose in hand. If Joe is a Consequentialist and Jo is a Kantian and Consequentialism and Kantianism are competing philosophical doctrines, it does not follow that for *any and every* particular moral situation if Jo ought to do such-and-such what Joe ought to do must be something different. It would be absurd to suggest that what is morally right for the one must, *for that reason*, be morally wrong for the competitor. It would, however, be equally absurd if their holding competing philosophical doctrines *never* made any difference, which is presumably the kind of absurdity Leavitt formulated his criterion to protect us from. The following reformulation of his criterion rules out this last absurdity but without leaving open the risk of sliding into the former, namely that which philosophical doctrine is held makes a difference in every practical case, which, for ease of future reference, I dub the Stringent Interpretation. The revised criterion asserts: a philosophical doctrine is relevant for medical ethics if and only if there are *at least some* particular practical moral situations in which someone who holds it ought to act differently from someone who holds a competing doctrine. Perhaps there should be a further stipulation that the difference(s) should be significant and not minuscule or trivial. Both Consequentialism and Kantianism satisfy the criterion thus revised, and so their relevance for medical ethics would no longer be in question.

The revised Criterion of Relevance says in effect that what makes a philosophical doctrine relevant to medical ethics may have very little to do with comparisons between people's behaviour, though not no connection at all. So if the substantive moral behaviour of the Kantian and the Consequentialist could be mostly indistinguishable, we should hardly expect to explain what makes the two doctrines philosophical competitors in terms purely or even

primarily of the comparative behaviour of those who hold the doctrines. What makes them philosophical competitors, of course, is that they systematically diverge as to what makes any given action right or wrong, to be done or avoided, and hence about the best philosophical account to be given of those moral phenomena. It does indeed make a difference, always, *which* doctrine someone holds, but the difference only sometimes consists in a commitment to *act* differently from those who hold the competing doctrine.

A brief illustration

Perhaps I should emphasize that although I have made the point in terms of two well known rival ethical theories they are simply illustrative of competing ethical theories in general. And the point is more general yet. I chose ethical theories as themselves instances of philosophical doctrines. I see no reason why other instances of philosophical doctrines, say metaphysical views, which fail to satisfy Leavitt's Criterion of Relevance (under its implausible Stringent Interpretation), should not meet the revised criterion and thus retain their relevance to medical ethics. A brief illustration. A certain sort of Dualist claims that we humans are possessed of a non-material soul. A philosophical rival, say a certain sort of Materialist, insists that we humans are wholly material entities. It would be absurd to suggest that the philosophical differences between Dualist and Materialist are irrelevant to medical ethics unless what they ought to do are the contrary of one another in any and every particular practical moral situation. Most of the time they will agree that health is valuable, that pain should be relieved, that Elsie Smith's gangrenous foot should be amputated, that Fred Dagg's conscientious refusal of a blood transfusion should be honoured; and so on. Nevertheless in some situations they part company, and do so under the influence of their metaphysical views. An adequate discussion of this would need much more space than I can give it here, but the situations I have in mind are likely to involve abortion, physician-assisted suicide, post mortem examinations, the use of animals in research, and no doubt more. The two rival views thus meet the revised criterion, and once again it must be stressed that what makes them philosophical competitors is not satisfactorily explained in terms of the comparative moral behaviour of those who hold them but in terms of how they *account* for the relevant behaviour, whether the individual agents concerned are in substantive agreement about what they ought to do or not.

The Stringent Interpretation requires that a differentiation of what behaviour is morally required of the holders of rival philosophical doctrines is both necessary and sufficient to establish the relevance of the doctrines to medical ethics. The revised

criterion in effect accepts that differences over what ought to be done in moral practice, where they occur, may be sufficient to establish the relevance of the doctrines in question to medical ethics. The other side of the coin is that, where no such differences occur, it does not follow that the philosophical doctrines are not relevant; that remains an open question. What does follow is that, if and when they are relevant, what makes them so *cannot* be accounted for in terms of contrasting moral behaviour for, by hypothesis, there is none.

The onus is now on me to say how I see philosophy contributing to medical ethics and indeed to other facets of everyday practice. My account begins with the idea that a philosopher is a theorist of foundations. Most philosophical problems raise questions about foundations, for instance about the foundations of our experience of the world, such as the causal and temporal connectedness of events. Moral philosophy tries to articulate the foundations of our moral experience.

It is worth seeing that moral philosophy is both distinct from morality and has a distinctive relationship to it. Morality is a whole complex of beliefs, judgments, actions, practices, institutions, and much more, which we begin to imbibe from an early age, and which becomes, for much of the time, 'second nature' (as we say about those facets of our lives – often practical things like driving a car – which we carry out fairly routinely). The moral judgments that we form, the moral decisions that we take, the moral actions that we perform as part and parcel of morality, typically *employ* various principles. It is, by contrast, however, relatively rarely that we *consciously articulate* what the principles in question are. That is true of a great deal of practical experience. It is usually only when we hit a problem or crisis that we are, as we say, forced to reflect about what we are doing. Such commonsense reflection, which we all do some of from time to time, is both about morality and yet also a part of it.

Reflection about morality

Ethics or moral philosophy is contrasted with morality in that it can *only* be reflective. Put at its simplest, moral philosophy is reflection about morality. That way of putting it emphasizes its continuity with commonsense moral reflection, that segment of morality of which we all have at least some experience. But what this simple way of making the point misses out is that ethics is *philosophical reflection* about morality. To say that ethics is philosophical reflection about morality is to make two general points about this branch of philosophy. Firstly, it is concerned with the foundations of morality, especially the principles and values which give it coherence, those assumptions which are mostly taken for granted, which are used in our moral behaviour but are relatively rarely

consciously articulated. Secondly, it uses a philosophical *mode of enquiry* central to which are clear analyses of concepts and careful evaluation of the arguments offered for and against different views.

One source of possible misunderstanding, however, stems, ironically, from the very notion of ethics itself. As a philosopher I take 'ethics' to be a synonym for 'moral philosophy', as will have been evident in the preceding discussion, but in many practical contexts 'ethics' is a synonym for 'morals'. Thus questions of the form: 'Would it be ethical to ...?' typically raise moral issues, and answers to them typically take the form of particular moral decisions and actions. The potential for confusion is considerable but, for all that, less widely recognized than it should be. Medical ethics, in providing a common meeting ground for physician and philosopher, may unwittingly blur the fact that the assumptions made by each diverge more starkly than the shared use of the term 'ethics' might otherwise suggest.

What I have been describing as moral philosophy or (philosophical) ethics might be more closely specified as 'pure' moral philosophy. Pure ethics is usually curiosity-provoked, unlike the crisis-provoked reflections of commonsense. That is to say, the moral philosopher is curious about morality when it is working well and not just when there is an emergency. And somewhere between the pure and the everyday or commonsense we have 'applied' ethics. Most applied ethics is, like commonsense, crisis-provoked, though it has implications for, and consciously utilizes the tools of, philosophical reflection. The boundaries here are fluid ones.

Let me draw the threads together. If medical ethics, and much the same applies to any other branch of applied ethics or applied philosophy, means thinking seriously, perhaps a bit harder than one otherwise might, about moral issues encountered in day-to-day medical practice, then it, though entirely worthwhile, need be no more philosophical in character than commonsense morality. Like the latter it will be practical in purpose, and there will be no reason to think that a philosopher can do it better than anyone else.

Philosophical ethics also requires serious thought about moral issues but the hallmarks of philosophical species of serious thought include what I have called a concern for foundations and a characteristic mode of enquiry. Philosophical reflection is something that a philosopher (and I use the label in a broad sense to include all who are familiar with this way of doing things irrespective of what their professional occupation happens to be) can do better than anyone else. One consequence of this is that the lay person *vis-a-vis* philosophy should expect to find a textbook of philosophical ethics as hard going as a lay person *vis-a-vis* medicine would find a treatise on gastroenterology. In both cases it is not impossible to cull most of what is valuable from those pages; but it

is hard work. It may be that the philosophical work is the more accessible of the two, for if the account I have given above is anywhere close to being right the ethics textbook should be putting into words what, when thus prompted, is familiar to us in experience.

Philosophical reflection has a theoretical rather than a practical aim, though the distinction between theory and practice is another which cannot be drawn as neatly as we might sometimes wish. We reflect in order to understand what is going on, but understanding what is going on has practical value too in so far as understanding a problem is a part – sometimes the main part – of finding a practical solution for it. So if medical ethics involves not just thinking seriously but thinking philosophically about moral issues in medicine, philosophical doctrines will have a relevance not just where they make a difference to what people do but more generally where they make a difference in understanding what is at stake.

Medical ethics includes a measure of reflection. Among the concepts which may merit reflection are a galaxy of moral concepts: duty, rights, justice, the sanctity of life, non-maleficence, and many more.

But there are also many non-moral concepts, such as person, death, competence, delusion, coercion, which merit as much serious attention. The philosophical theories and doctrines through which these reflections are expressed embrace metaphysics as well as ethics. Both may have a contribution to make to medical ethics, and so we cannot keep metaphysics out of medical ethics for much the same reason we cannot keep (philosophical) ethics out of it. But we can make sure, that is try to make sure, that it helps.

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Reference

- (1) Leavitt F. Let's keep metaphysics out of medical ethics: a critique of Poplawski and Gillett. *Journal of medical ethics* 1992; 18: 206–209. All the quotations in my text are from Leavitt's essay and are acknowledged by a page number in parentheses.

News and notes

Caring for Survivors of Torture

The seventh international symposium on 'Caring for Survivors of Torture: Challenges for the Medical and Health Professions' will be held in Cape Town, South Africa from 15–17 November 1995.

The conference is being organised by the International Rehabilitation Council for Torture Victims (Copenhagen) and the Trauma Centre for Victims of Violence and Torture (Cape Town). The plenary sessions, workshops, panel discussions, and seminars will focus on the following topics: 1. Diagnosis and treatment of physical sequelae of torture; 2. Diagnosis and treatment of psychological sequelae of torture; 3. Family and community approaches to the provision of health services for torture survivors; 4. International action towards the rehabilitation of torture survivors; 5. Experiences of health workers with torture and rehabilitation in African countries; 6.

Experiences of health workers with torture and rehabilitation in the rest of the world; 7. Health perspectives on truth-telling, reconciliation, and impunity for survivors of human rights violations; 8. Torture, ethics, and the health professions; 9. The prevention of torture: methods of training and educating health professionals; and 10. The social psychology of state-sponsored violence: do we treat perpetrators?

For further information contact either: International Rehabilitation Council for Torture Victims (IRCT), Borgergade 13, PO Box 2107, DK-1014 Copenhagen, Denmark. Tel: (45) 33-76-0600, fax: (45) 33-76-0500, or the Trauma Centre for Victims of Violence and Torture, Cowley House, 126 Chapel Street, Cape Town 8001, South Africa. Tel: (27) 21 45 7373, fax: (27) 21 462-3143.